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THE DYNAMICS OF PLANNING IN HEALTH EDUCATION*

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Program planning is a basic concern in public health practice. That the public health educator has an important role in planning is best evidenced, not by what health educators say about their own functions, but by what their colleagues say. The World Health Organization reports of the expert committees in Mental Health,† Nursing,[2] Environmental Sanitation,[3] Venereal Infections,[4] Malaria,[5] Nutrition,[6] School Health,[7] Public Health Administration,[8] and Maternity Care,[9] leave little doubt that the other disciplines in public health look to the skills of the health educator in planning ways to meet their educational objectives.

Thus we are not only wanted but needed when programs in public health are being planned. Moreover, we have principles drawn from educational theory[10] to guide us which are reflected in the questions we raise and the suggestions we make whenever we work with others. Some of these principles are uniquely our concern because we are educators; others we share with *all of the public health family* because they, too, are well grounded in the steps of program planning.

The steps of program planning are common knowledge. They are similar in all types of administrative work. They provide the structural framework of planning. Mustard,[11] outlines them succinctly beginning with the preliminary survey of problems and resources and ending with the testing of modifications of procedures. He adds these words which have direct import to the health educator whose job it is to serve *all* staff in a health department and to help the health department, as a functioning entity, find its place in a coordinated effort to serve people. He says,

> "The whole constitutes health practice, each phase of which is related to every other one and to the health department's service as a whole. These relationships should never be forgotten. No single activity should be allowed to dangle, which it will do, unless it gives support to, receives support from, or is interrelated with its associated services; and the health department, in its entirety, needs to be viewed not as an entity in the community but as one of a number of interdependent elements in organized society."

Many of our unique contributions to the structural framework of planning are directly focused on achieving these two objectives — cohesiveness within the health department and cohesiveness within the community. Our efforts in planning sessions are often directed solely toward these goals.

More is needed in planning, however, than a structural framework. What converts the structure into a functioning unit? What alchemy transmutes procedures into processes? What takes place within a structure that gives warmth and satisfaction to living therein — or the opposite? When does a house become a home?

It is to these questions we must find answers. One ready response is that we bring a structure to life through "teamwork." Others are that "all must share in the planning"; we must "communicate." We, as health workers, must not be misled by believing that the use of a word or a phrase is *ipso facto*, a solution. Without digging a bit deeper into the dynamics of the meanings of these words for us personally, we are likely to be numbered among the many who give lip-service. Thus we have need, (1) to analyze the assumptions which we accept as basic in planning; (2) to discover what participation in planning *is* and what it demands of us; and (3) to assess the importance of planning as a professional experience.

Assumptions Basic to Planning

There are many hypotheses underlying the empirically derived steps which we follow in the planning process. Of these, there are two of importance for this discussion. The first is that our contributions to planning have their roots, deeply imbedded, in a philosophy of democracy. It is a philosophy which implies that leadership is not a prerogative of status or power personages, but that leadership is a shared responsibility of all members of a particular group. It is easier to accept this assumption intellectually than to act on it.

As a safeguard against confusion, let us state firmly at this time that we are as aware of the wastefulness of *under-planned* programs inherent in the laissez faire philosophy, as we are of the short-range results of *over-*

* A digest of a presentation to the Health Education Workshop, Asilomar, 1955.
† See page 52 for bibliographical references.

planned programs of authoritarian leaders.

The second assumption is that each life situation with problems whose solutions involve planning, has its specific *degrees-of-freedom* within which planning must be done. There is no conflict between democracy and degrees-of-freedom. Democracy in practice is an orderly process; a process in which responsibility and authority are given to agencies and persons. But in each agency, in each differing situation *within* an agency, there are degrees of freedom of action specific to the situation. Thus it is necessary in program planning to *test* continually the degrees of freedom for constructive action, to ascertain the *real* boundaries beyond which planning cannot go. Lack of recognition of the assumption of the specificity of degrees-of-freedom is shown through two extreme examples.

One is that of a community group which made elaborate plans for presenting the need for a mental hygiene clinic to the county board of supervisors without assessing the availability of funds, the difficulties in recruiting personnel, the time necessary to develop a program coordinated with other community agencies, or the locus of legal authority for initiating the clinic. This is like the child who sees no reason why he cannot reach for and touch the moon.

The other extreme is found in planning groups that fail to test the boundaries of their freedoms *sufficiently*. They accept as final the first limitation that arises; they do not investigate the avenues which might lead to their goals. They are easily battered down by a "NO" spoken with authority. Thus they do their planning within limits that are narrow and confining. The job is like the work of squirrels in a revolving cage where the outside world is not for them. Creativity of exploration is not there—only mediocrity.

The role of the health educator is clear. With the first group he must open their eyes to the existence of barriers and their subsequent exploration. With the second he must help them see that a limitation is not a barrier until a dozen ways have been explored. Both of these tasks are creative endeavors.

The Nature of Participation

Alpert and Smith [12] have given an analysis of why participation of others is needed in planning, at what points it is needed, and what happens during participation.

They are careful to distinguish between *activity* and *participation*. Activity in an office, a classroom, or a Boy Scout meeting may not mean that the staff, students, or Boy Scouts are operating as participating members of their respective groups. They may be working only as *agents* of the group; they are "carrying out" orders which one person (the director, teacher, or leader), or a small executive committee has delegated to them. This is a nice distinction to think about in planning programs *for* or *with* volunteers.

The authors point out, too, that when a person has not been involved in planning what he will do, he often is inefficient; he makes mistakes; or he falls back on manuals and rules which he applies mechanically because he does not know the thinking that went into making the policies. His work security rests on carrying out the printed word. This is a reason, not commonly used, in arguing for broader participation by staff in policy making.

They state that participation is needed in three planning stages—namely, in the *definition of the problem, the discussion of the approaches,* and in the *working through of the selected solution.* The values of group thinking are not productive in a long-range program when group thinking is used only in determining objectives. An application of "group thinking" to a problem is not comparable to an injection of an immunizing agent. Starbuck's [13] research showed that. One of the chief breakdowns in establishing continuing clinics for giving topical fluoride treatments to school children was found to be in those communities where the planning committee did not participate in defining the methods to be used in the work and were removed, as participants, from any responsibility for the methods selected. These emphases are not new to us.

Nor, are we hearing something new when Alpert and Smith, in leading their discussion of the nature of participation, tell us once more as have Lewin, Allport, the Overstreets and many others, that all we bring to any meeting is the limited life experience each one of us has had. But perhaps it is a good idea to remind ourselves of our lack of omniscience, of our need of the experiences of others to extend our own life space. Only the simplest of problems can be solved wisely by the experience of one person.

Granted, then, that we accept this need for others participating in planning. What happens in our inner world of ideas and values when our suggestions are challenged, criticized or discarded? What processes take place in our minds and emotions when wholly new approaches are suggested, something not in our life experience? The authors suggest that two processes are constantly interplaying, one of analysis, the other of synthesis. When a new or contrary idea is given, we immediately tear it into little bits, take its measure for size to see if it will fit into our own pattern of thinking (it is the only pattern we have) and, depending on the fit, start the second process, that of synthesis or restructuring. If the fit is very bad we become disturbed, tense and unhappy. To regain equilibrium we may have to reject the criticism or the new idea. Or we may be able to stretch one of our ideas or values to include at least part of the new idea. But something *has* to be done about it. And what will be done about it is different for each person in the group. Within each person faced with giving up or questioning some cherished value or idea, tension is induced.

Thus we can understand why planning sessions for many people are painful experiences. So uncomfortable in fact that they shy away from them, giving various reasons for so doing. A bit later we will look at the ways some of us who continue to participate in planning react under tension. But first we must look at the tension phenomenon. Is it necessary as a personal experience, if change is to take place? Under what conditions are tensions produced and alleviated?

Our work in group process at the School of Public Health may be of some help here.

Our experience has indicated that new ideas are not freely expressed or accepted by a group, unless there is

an attitude-set among the members that *analysis is a desirable thing to do,* and a feeling exists that ideas need to be put under the microscopes of a dozen different pair of eyes. Further, the "feeling" must be present that whatever these many eyes see, has *value.*

A group of graduate students during the first few weeks of working together go through various stages of participation involving tension. The first stage is inevitably one of subtly or not so subtly sparring for status with each other and with the instructor. Each member is trying to find out who the other fellow is and to establish his own right to be there. During and following these meetings there are evidences of tension in most of the members. They are being forced to make adjustments in perceptions of themselves (analysis and synthesis) and this is painful to some for a short time. The second stage is marked by growing warmth of feeling between members. Friendliness and informality of interrelations are evident. But in the discussion of problems, the level is actually one of polite and intelligent exchange of information. Deviates within the group who wish to jump ahead are handled by the group in one of a dozen ways groups use to maintain desired equilibrium. Participation is different in kind and quality from that of the first stage but still lacks the depth of analytical thinking.

Yet tensions are developing during this apparently calm period. It is as though the members felt inadequate to take the next steps which the permissive atmosphere makes possible; steps to which verbally they have committed themselves in developing their objectives. There are inner pressures to dig deeper but they hesitate; it may mean a disruption of the "polite" atmosphere in which each feels secure.

Only when these tensions are consciously felt by approximately two-thirds of the group and they demand of themselves, each other, and the instructor to know why they are here—what is it all about—that analysis of ideas and appraisal of self and others begin. Tensions of a new type are now seen; tensions of frustration, anger, disgust, rejection, and anxiety. Too many new items are pouring in from the outside. There is not sufficient time to restructure them. Personal equilibriums are threatened in these exchanges of opinion and value judgments, even though they are on a superficial level and have little resemblance to the more personal types of interchange that take place in group therapy sessions.

The individual weathers this period, however, but he weathers it only because of what has gone before and what is developing. This intangible called "group support" is now at his elbow. It is in and around everyone. He begins to realize that *he* is accepted even though his ideas are not. And as this fear of rejection of the self by the group grows less and less, the individual becomes correspondingly freer to suggest, to contradict, be angry, to laugh, to work on the problem. There is a "loosening" effect; a kind of relaxation gradually begins to be exhibited by everyone.

But within the sequence of over-all changes in group behavior there is great variability in the reactions of individuals. These differences seem to depend on the *tolerance to tension* of each person. He participates in the analytical process only to the point where he can endure the tensions produced. Various stereotyped responses indicate low levels of tolerance:

a. The person indicates that the statement made is untrue, quoting personal experience. He does this in an authoritative tone of voice, seeking to prevent further exploration of the idea.
b. He raises questions obscuring the real point and introduces vague philosophical considerations with which the group cannot cope.
c. He uses words, facial expressions or other gestures implying it is ridiculous to discuss the matter further.
d. He indicates that his idea is that of the "administrator" or some other status person.
e. He expresses immediately and convincingly a dozen reasons why the idea is "bad."
f. He remains silent and tense.
g. He shrugs off the idea with wise cracks.
h. He engages in impulsive side-talk with his neighbor.

All of these are symptoms of uneasiness. At the moment of occurrence they are psychological barriers to planning and teamwork. They are defenses raised by the individual to protect himself. And their effects on group movement are evident. Often there is complete blocking of further discussion. The blocking may be accompanied by feelings among members that no degrees of freedom exist within which to continue discussion. They feel "caged." They fear failure.

But the symptoms which appear so frequently during the first six weeks become less and less. During the final weeks of the course they are sporadic and easily accepted by the group. Group members feel comfortable with one another. New ideas and values are no longer threats. They are a source of wealth to the group.

It is more difficult to pin-point the behaviors of persons who have a high tolerance for tension. These are the persons with whom we enjoy talking, planning, working. To be with them is a satisfying experience. Such people are not reticent in sharing ideas, opinions and value judgments. They are enthusiastic about their ideas. But there are at least two characteristics which differentiate them from others with lower tolerance for tension.

The first is that *what* they say or *how* they say it does not induce a feeling of closure with the group. Discussion isn't blocked; freedom isn't curtailed. The second difference is that one senses an inner flexibility within this person which permits him to withhold judgment for considerable time. He is not afraid of being uncertain. It is as though he were undisturbed by the "new pieces" which he must restructure into his old patterns. He can wait without discomfort. Growth in attaining greater degrees of flexibility is often an outcome of satisfactory experiences in participation.

Participation, *per se,* is evidently a continuum. At one end is the superficial involvement of persons in their first meetings together, or in their participation in checking items on a questionnaire. At the other end is a participatory experience bringing about growth and change within the individual. In between these extremes are the forms of participation in which members obediently carry out what they are requested to do; or

that provide for exchange of opinions and information; or that result in developing plans in sterotyped ways.

These are qualitative differences. Apparently there are no short-cuts, no magic to produce growth and change in people in three short meetings. The barriers to developing satisfying experiences in participation are real. Lack of time and geographical distance make it impossible to achieve real participation in planning groups whose members are scattered and whose meetings together are limited.

But within the agency where we work there are opportunities to go the whole way, if we but see them and if our own level of tolerance for tension permits us to use them. It is in work with staff that we are able to test our skills in the process of participation as it is related to the various stages of formal program planning. It is here that we will be able to see our own growth and that of others.

The Meaning of the Planning Process for the Health Educator

For us the blueprint of a planned program is not a starting point for action but the end result of a long series of actions. Each step has been achieved through the participation of many people. And the validity of these steps, in a large part, depends upon the kinds of participation that have taken place and the quality of the participation.

For others it often appears that the *outcomes* of planning have priority. For us the *process* of planning, what happens in planning sessions, comes first. Not that we lack interest in program planning outcomes; but we know the results will be good only if the planning process has been good.

The planning function of our work is our major teaching function. Here it is where we accomplish most; here it is where our efforts are multiplied by the number of others who serve with us. And it is in our increased insight into the dynamics of planning that our personal and professional growth lies.

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Federal Polio Vaccine Study Funds Allocated to State

An allocation of $250,000 in federal funds has been granted the State Department of Public Health to study the effectiveness of the Salk polio vaccine in California children and to intensify the State's polio surveillance program.

The surveillance program, an integral part of the national polio intelligence network, will note the incidence of the disease in vaccinated and nonvaccinated persons to determine the efficacy of the vaccine, and to maintain a vigil on the use and distribution of the vaccine in California.

A plan for the equitable distribution of polio vaccine in the State has been completed by the department's Advisory Committee on the Prophylaxis of Poliomyelitis and is now in operation. All supplies of vaccine released in August were channeled to the commercial market.

While a plan for the purchase of vaccine supplies for public agencies has not yet been approved by the U. S. Surgeon General, the department has requested that 25 percent of vaccine supplies released for California in September be earmarked for public use, with the remainder directed to the commercial market.

Dr. Halverson Honored By President Eisenhower

Wilton L. Halverson, M.D., former State Director of Public Health, has been named by President Eisenhower to the International Development Advisory Board. The appointment is for a two-year term beginning September 25, 1955. The board advises the President on the government's program on international technical assistance.

Dr. Halverson is eminently well qualified for membership on such a board. He came into national and international prominence in public health during his 11 years as head of the California State Department of Public Health. As an alternate delegate he represented the United States at the First World Health Assembly in Geneva and attended the second meeting of the executive board of the World Health Organization in 1948.

Since his resignation as State Director of Public Health, Dr. Halverson has been chairman of the Department of Preventive Medicine and Public Health of the U. C. L. A. School of Medicine and in charge of the Department of Public Health as associate dean of the University of California's School of Public Health on the Los Angeles campus.

Rocky Mountain Spotted Fever Found in Unusual Locations

A confirmed case of Rocky Mountain spotted fever, a tick-borne disease usually found only in the northeast section of California, was recently reported in a Hayward rancher and a suspected case of the disease also was reported from San Joaquin County but still is undergoing laboratory tests for confirmation.

Immediate surveys of the areas failed to find the type of tick which is linked ordinarily with the disease. Consequently there exists no likelihood of an outbreak of spotted fever in these localities.

However, since the Hayward rancher reported he had not been out of the area for more than two years, extended epidemiological and entomological investigations will be continued by the Bureaus of Acute Communicable Disease and Vector Control of the State Department of Public Health.

Tumor Registry Results Prove Early Treatment Prolongs Life Of Cancer Victims

The over-all chance of survival for at least five years after treatment for cancer is now 23 percent, according to information from the California Tumor Registry, a cooperative project of the State Department of Public Health and 37 California hospitals.

Records of the registry disclose that if cancer is treated while still localized to one area of the body, the five-year survival chance rises more than 50 percent. On the other hand, if the disease is far advanced with spread to distant parts of the body before treatment is undertaken, the likelihood of being alive five years after treatment drops to less than 10 percent.

In general, the analysis indicates that approximately one-fourth of the patients with cancer in California are being "cured" in the sense of five-year survival; another one-fourth, or a total of at least one-half of all cancer patients, could be similarly benefited if current knowledge were fully applied and all patients treated while the disease is still localized. This would mean a saving of 5,000 lives each year in California, lives which are now being lost unnecessarily.

The Tumor Registry, now used as a model by the American College of Surgeons and other health agencies, contains data on more than 130,000 cancer cases, some of them followed since 1942. This body of information provides a means of studying the extent and nature of the cancer problem.

It also assists in the evaluation of diagnostic methods, treatment and survival of cancer cases; advanced studies of the epidemiology of the disease; indicates leads for clinic and other types of research; and provides facts for professional and lay education. It also promotes continuing care of the cancer patient since it insists upon and provides for an effective system of follow-up.

From its inception in 1947 the registry has had the support of the Association of California Hospitals and the Cancer Commission of the California Medical Association. At the present time approximately twice as many hospitals as are now in the registry desire to participate but cannot be accommodated because of the lack of departmental resources.

Fewer Mosquitoes May Be Reason For Low Encephalitis Rate

Up to this time encephalitis cases in the State have continued to occur at an unusually low rate. Last year during this period there had been six cases of Western equine encephalitis and 14 of the St. Louis type; this year only three cases of Western equine infection and none of St. Louis infection have been diagnosed with laboratory confirmation. The ages of these cases are typical of Western equine infections: three and a half weeks, one month, and 10 months. One death from suspected encephalitis in an infant was reported late in July.

Temperatures in the Central Valley were below normal early in the season and the mosquito population was down, factors which might account in part for the low disease incidence.

A total of 366 initial blood specimens were submitted to the Viral and Rickettsial Disease Laboratory during June, July, and August, compared to 686 specimens submitted during the same three months a year ago.

While both Western equine and St. Louis viruses were identified in mosquitoes in July and August a year ago, only Western equine has been isolated so far this year. Of 738 mosquito pools tested this year, only 36 have been reported positive (Western equine).

No cases of encephalitis among horses were reported to the State Department of Agriculture from January through May, but notifications of 10 cases were received during April, June, and July.

Sierra and Trinity Counties Contract For Public Health Services

Public health services will be provided Sierra and Trinity Counties as the result of contracts recently completed between the State Department of Public Health and the boards of supervisors of the two counties.

Under the contracts, as provided for in Section 1157 of the Health and Safety Code, the department agrees to plan and direct the health programs and will assign public health nurses and sanitarians to the counties on a full-time basis.

In Trinity County the program will include sanitation, nutrition, studies of housing needs, communicable disease control, tuberculosis and venereal disease control, maternal and child health and school health services. The Sierra County program will include most of the services mentioned above, in addition to special studies of existing health problems and needs.

Both counties have budgeted an amount greater than 55 cents per capita and will also contribute toward the public health program by providing part-time services of the county health officer, clerical services and office space for state personnel.

A total of four counties currently are contracting with the department for such services.

Study Probes Relationship Of Chronic Disease to Occupational-Environmental Factors

An investigation to determine the relationship of occupation and other environmental factors to heart disease, cancer and other chronic diseases has been instituted by the Bureau of Chronic Diseases of the State Department of Public Health under a three-year, $150,000 grant from the Rockefeller Foundation.

It has been suspected for a long time that environmental influences play a major part in the incidence of chronic disease; now this study will concentrate upon an understanding of these influences. It is expected the information gained from the investigation will contribute substantially to the department's chronic disease prevention program.

The grant, the first of its kind ever awarded by the Rockefeller Foundation, comes after several years' study in which the department identified certain occupations as probable factors in the causation of lung cancer, and in which the role of cigarette smoking in cancer was confirmed.

A study team, including a physician and a social research technician, will organize and carry out project field studies.

Public Health Positions

Kings County

Physicial Therapist: Salary range, $376-460. Positions open for work in cerebral program. Qualifications will determine starting salary. For further information contact Donald E. Upp, M.D., Director, Kings County Health Department, 1221 W. Lacey Blvd., Hanford.

Public Health Nurse: Salary range, $343-411. Generalized program; liberal personnel policies; car furnished. Apply as above.

Sanitarian: Salary range, $299-343. State certificate of registration required. Generalized program; car furnished. Apply as above.

Los Angeles

District Health Officers: Salary range, $8,500-10,668. Positions are available in Los Angeles City for physicians with training and experience in public health administration. California license to practice medicine required. For further information contact George M. Uhl, M.D., Health Officer, Los Angeles City Health Department, 111 E. First Street, Los Angeles 12.

Merced County

Senior Public Health Nurse: Salary range. $341-415. B.S. degree and one year of experience required. Apply Merced County Personnel Department, Courts Building, Merced.

Public Health Nurse: Salary range, $325-395. PHN certificate required. Apply as above.

Oakland

Sanitarian: Salary range, $400-460. State certificate of registration required. Residence waived. Tentative filing date for examination, October 22d. For further information write or telephone the Oakland Civil Service Commission, 323 City Hall, Oakland.

San Diego County

Laboratory Technician II: Salary range, $296-360. Positions open in the clinical laboratory of a large general hospital in a residential district near a metropolitan center. Immediate appointment will be made. Applicants must have a clinical laboratory technician's license issued by the California State Department of Public Health before permanent appointment. County and state residence has been waived for this examination. Applications will be received until further notice by the Department of Civil Service and Personnel, Room 402, Civic Center, San Diego.

Santa Barbara County

Public Health Bacteriologist: Salary range, $307-373. Laboratory director for Santa Barbara County Health Department laboratory at Santa Maria. Experienced and qualified bacteriologist may start at third salary step. California certificate as a public health bacteriologist required. Apply to Joseph T. Nardo, M.D., Health Officer, Santa Barbara County Health Department, P. O. Box 119, Santa Barbara.

State of California

Physician and Surgeon I: Beginning salary, $676. This class may be used as an entrance class in the State Department of Public Health. Those employed here receive training in public health practices and assist with public health programs. Final filing date for examination, November 15, 1955; written test date, December 6, 1955; interview date, January 10, 1956. Nation-wide examination given in California and other states as warranted. Possession of the legal requirements for the practice of medicine in California and completion of an internship in an approved hospital and U. S. citizenship required. Applicants who are in the process of securing approval of their qualifications by the State Board of Medical Examiners and those serving an internship will be admitted to the examination but they may not be appointed until license requirements are met. (Applicants who are graduates of approved medical schools in the U. S. or Canada and licensed in another state may be employed in a California institution before securing a California license. All questions regarding this provision and applicants' qualifications must be directed to the California State Board of Medical Examiners.) Application blanks are obtainable from the State Personnel Board offices in Sacramento, San Francisco, and Los Angeles or at local offices of the California Department of Employment. Applications filed by mail must be addressed to the State Personnel Board, 801 Capitol Avenue, Sacramento.

Industrial Hygiene Institute To Be Held in Santa Ana

The Bureau of Adult Health of the State Department of Public Health will conduct their annual Institute on Industrial Hygiene in the new Health Center auditorium of the Orange County Health Department, Santa Ana, on November 3d and 4th.

The main theme will be environmental control by ventilation. This will include temperature, humidity and radiant heat as major problems encountered by the local health department sanitarian in his routine work.

An aspect of public health nursing will also be included together with an outline of occupational disease and essential information about the functions of the department's Bureau of Adult Health.

Local health officers and others concerned will be notified directly of the institute and invitations will be extended through them to personnel of every discipline within the local health department, although the topic of this particular institute is of special interest to the local health department personnel in the environmental field. Most of the attendance is expected from the area of the State south of Fresno.

Public Health Training Service Established in Department

A Public Health Training Service was recently established in the State Department of Public Health as a first step in the organization of an educational program for departmental personnel.

As a unit of the Division of Administration, the service will conduct inservice education programs on problems and needs of mutual concern; orientation activities concerning department programs, policies and relationships; and coordinated planning and development of training programs for professional personnel, including academic, field and inservice experiences.

The Training Service also will provide informational and consultation services to administrative units in the department in planning and conducting training programs and will facilitate the use of inservice education opportunities and resources of other agencies.

Miss Lucretia Saunders, a former member of the Bureau of Health Education, has been named chief of the new service.

In connection with the formation of the new unit, Dr. George T. Palmer, training officer, will assume responsibility for special assignments and consultation in the field of public health administration and serve as consultant to the new training service. He also will handle the programs of the many foreign visitors who come to the department.

Ole Hendrickson, Former Employee, Dies in Sacramento

Ole J. Hendrickson died in Sacramento on August 29th, slightly more than a year after his retirement from the staff of the State Department of Public Health for disability. He was 62 years old.

Mr. Hendrickson joined the staff of the department in 1942 as a sanitary inspector in the Sacramento area and held that position for 12 years.

His many friends in public health circles in the State will be saddened to hear of his death.

Polio in California Is Well Below the 1954 Incidence

Poliomyelitis in California through September 3d remained well below that reported in 1954, with indications this trend will be maintained for the remainder of the year.

Since April 1st and through the end of August, there were 864 reported cases of polio, compared to 2,365 reported during the comparable period a year ago. For the week ending September 3d, there were 62 cases reported, compared to 259 during the corresponding week of 1954.

Thus far, 81 percent of the total cases have been reported from 11 counties, with Los Angeles leading with 448 this year, compared to 1,042 a year ago. The other leading counties, showing first this year's and then the 1954 total reported cases are: San Diego, 57 to 99; Alameda, 37 to 108; Orange, 34 to 122; Contra Costa, 22 to 158; Kern, 20 to 86; Stanislaus, 18 to 53; San Bernardino, 18 to 52; Santa Clara, 18 to 58; San Mateo, 16 to 59, and Sacramento, 15 to 52.

Insufficient data had been accumulated at the conclusion of this report period to indicate the effectiveness of the polio vaccine.

State Nursing League To Hold Convention

"Helping People Is Our Business" will be the theme of the third annual convention of the California League for Nursing when members and guests meet at the Hotel Leamington in Oakland on October 20th through the 22d.

Highlights of the program will include a panel to consider the effect on the community and other health professions of standards and changes in nursing education. A discussion of the two-year experimental junior college program will be of interest. The practical use of mental health concepts in everyday association with patients, students, coworkers, and members of the community, will be discussed and demonstrated through group work. There will be a report from the center for Advanced Study of Behavioral Sciences at Stanford University. Ruth B. Freeman, President of the National League for Nursing and Associate Professor of Public Health Administration at Johns Hopkins, will address the convention on present trends in nursing service.

Cancer Film to Be Shown Over Entire State

The California Division of the American Cancer Society and its local branches have undertaken arrangements for mass showings for women of the film "Breast Self-Examination" throughout the entire State during the latter part of October and the month of November.

This film, produced by the American Cancer Society in cooperation with the National Cancer Institute, has been shown for several years in California but it is estimated that not more than 5 percent of women in the State have actually seen it. The aim of the intensified effort is to reduce breast cancer mortality in women by providing the maximum opportunity for every woman to see the film and be made aware of the need for self-examination of the breasts.

Because the supply of films is limited it is not possible to conduct showings throughout the entire State simultaneously. Accordingly, the State has been divided into eight zones. The Cancer Society plans to arrange for showings of 35 mm. prints in theaters and of 16 mm. prints in other locations.

Civic Leader Named Public Member Of Polio Advisory Committee

Mrs. J. E. Manley, of Healdsburg, has been named by the State Board of Public Health to represent the public on the department's Advisory Committee for the Prophylaxis of Poliomyelitis. She also will serve as a member of the advisory group's subcommittee on the allocation of vaccine supplies in California.

Mrs. Manley is a member of the Sonoma County Advisory Committee on Health Education and serves on the board of the Sonoma County Mental Hygiene Clinic. She currently is assistant legislative chairman for the California Congress of Parents and Teachers and formerly was a member of the organization's Special Educational Committee.

Diagnostic Center Established For Cerebral Palsied Children

A new College of Medical Evangelists service for cerebral palsied children was assured last month after the State of California requested that the college establish a diagnostic and treatment center at the White Memorial Clinic. Contract with the State has been approved by the President's Committee, according to Dean of Faculties Keld Reynolds. CME will cooperate particularly with the State School for Cerebral Palsied Children now operating in Altadena. The budget provides $17,000 for setting up additional service at the White Memorial Clinic under the direction of Drs. Robert Chinnock and Joseph Maschmeyer.

Five Additional Beds for Recalcitrant Tuberculous Made Available at Medical Facility

To meet an increasing demand for additional space, the number of beds being made available to tuberculous recalcitrants at the California Medical Facility at Vacaville has been upped from 25 to 30.

Only by adhering to a rigid quota from the larger countries has the waiting list for admission been kept within bounds. The additional beds for these patients sent in from counties was arranged by agreement between the Bureau of Tuberculosis Control and the Medical Facility of the State Department of Corrections.

Student Training Proves Valuable For Future Bacteriologists

Fourteen local health department laboratories are cooperating with the State Department of Public Health in its Student Professional Assistant program for the training of qualified public health bacteriologists.

The assistants, for the past year, have been receiving part of their six-months training experience in local public health laboratories, a program which presents an opportunity for them to participate in everyday problems faced by bacteriologists in actual practice in the community.

Suicide is a major cause of death in the United States, ranking ninth in some tabulations, and higher than that in the 45-to-65 age group. It causes 10 times as many deaths as polio, and in some areas it outranks tuberculosis, traffic fatalities, and cancer of the breast or respiratory system. Yet most suicides could be prevented, according to Dr. A. E. Bennett, associate clinical professor of psychiatry at the University of California Medical Center.

Dr. Bennett said many deaths could be prevented by compulsory psychiatric followups on all persons who attempt suicide. At present, he said, most suicidal patients are released from emergency hospitals when they are out of physical danger, and many of them later succeed in killing themselves. Also, Dr. Bennett said, many lives could be saved if physicians and the public more often recognized and acted upon the danger signals of severe depression which precede most attempts at suicide.—*U. C. Clipsheet*

Review of Reported Communicable Diseases Morbidity by Month of Report August, 1955

Diseases With Incidence Exceeding the Five-year Median

Diseases	*August, 1955*	*August, 1954*	*August, 1953*	*Five-year, median*
Amebiasis	72	33	18	34
Brucellosis	8	4	6	7
* Coccidioidomycosis	18	2	3	3
Food poisoning	176	39	337	47
Hepatitis, infectious incl. serum hepatitis	142	149	106	46
Measles	982	1,070	1,177	862
Mumps	1,406	866	994	777
Pertussis	432	522	118	327
Rabies, animal	44	7	18	9
Salmonella infections	105	86	65	65
Shigella infections	160	133	109	79
Streptococcal infections, resp. incl. scarlet fever	198	186	116	137

Diseases Below the Five-year Median

Diseases	*August, 1955*	*August, 1954*	*August, 1953*	*Five-year, median*
Encephalitis (western equine)	3	6	4	6
Encephalitis (type undetermined)	7	30	17	30
Malaria	2	2	16	5
Meningitis	13	14	31	22
Poliomyelitis (total)	315	995	660	561
Poliomyelitis (paralytic)	143	539	339	371
Typhoid fever	9	13	9	13

Venereal Diseases

Diseases	*August, 1955*	*August, 1954*	*August, 1953*	*Five-year, median*
Syphilis	824	423	454	523
Gonococcal infections	1,399	1,305	1,226	1,342
Chancroid	10	8	8	[1]
Granuloma Inguinale	---	3	---	[1]
Lymphogranuloma Venereum	3	5	7	[1]

* Prior to July 1st only disseminated form was reportable.
[1] Median not calculated.

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